



April 2015

# MEDICARE ADMINISTRATIVE CONTRACTORS

## CMS Should Consider Whether Alternative Approaches Could Enhance Contractor Performance

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#### Why GAO Did This Study

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to select claims administrative contractors through a competitive process and to do so in accordance with the FAR. In fiscal year 2013, MACs processed almost 1.2 billion claims totaling more than \$363 billion in Medicare payments.

GAO was asked to assess CMS's implementation of contracting reform and examine whether CMS could do more to increase MACs' effectiveness. This report evaluates (1) differences in responsibilities among MACs and the costs associated with these responsibilities, including any changes since the implementation of contracting reform; (2) lessons learned, if any, since CMS implemented contracting reform that could be used to increase MAC efficiency and effectiveness; and (3) alternative contracting approaches that CMS could use to enhance contractor performance. To do this work, GAO reviewed the FAR and CMS documents—including contracting documentation and MAC cost reports—and interviewed officials from CMS and selected MACs. GAO also reviewed the FAR to identify alternative contracting approaches.

#### What GAO Recommends

GAO recommends that CMS conduct an analysis to determine whether alternative contracting approaches could be used to help promote improved contractor performance. In its comments, the Department of Health and Human Services concurred with this recommendation and said it plans to analyze alternative contracting approaches for MACs.

View [GAO-15-372](#). For more information, contact Kathleen M. King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov).

#### What GAO Found

As of February 2015, 16 Medicare Administrative Contractors (MAC) administered claims submitted by Medicare providers and suppliers. Twelve were A/B MACs that administered Medicare Part A and Part B claims for inpatient hospital care, outpatient physician and hospital services, and home health and hospice care, among other services, in specific jurisdictions. Four other MACs administered claims for durable medical equipment (DME).

GAO found that the A/B and DME MACs are typically expected to carry out similar key responsibilities, a few of which—including claims processing and customer service—have accounted for most of their reported costs. Since the implementation of contracting reform, beginning in 2006, the key responsibilities included in MACs' statements of work have generally remained consistent, with limited exceptions. Further, while similar key responsibilities accounted for the majority of A/B MACs' and DME MACs' costs, there were some differences between A/B MACs and DME MACs in the shares of total costs that were accounted for by certain responsibilities. For example, the DME MACs spent a higher portion on appeals, on average, than did the A/B MACs.

Officials from the Centers for Medicare & Medicaid Services (CMS) and the MACs that GAO interviewed have identified lessons learned since the implementation of contracting reform, and they have made improvements to increase operational efficiency and effectiveness. For example, MACs have developed Internet-based provider portals to reduce expenditures on telephone-based provider customer service. However, both CMS and MAC officials identified challenges for continued improvements in MAC efficiency and effectiveness, such as MACs' desire to protect their competitive advantage by not sharing certain innovations or operational improvements with other MACs.

CMS selected a cost-plus-award-fee contract structure for the MACs when it initially implemented contracting reform. This is a type of cost-reimbursement contract that allows the agency to provide financial incentives for achieving specific performance goals. While CMS has made modifications to its cost-plus-award-fee structure for MAC contracts—such as revising the performance metrics included in MACs' award fee plans and adjusting the distribution of award fees across the metrics to promote performance in areas where MACs have performed poorly in the past—the agency has not formally revisited its MAC contracting approach since the implementation of contracting reform. Moreover, its assessment of alternative contracting approaches has been limited. The Federal Acquisition Regulation (FAR) states that changing circumstances may make different contracting approaches more appropriate later in the course of a series of contracts or a long-term contract than they were at the outset. Further, CMS indicated in its 2007 MAC acquisition strategy that once a baseline cost and level of effort had been established, the agency would reassess whether the cost-plus-award-fee contract structure was still appropriate for the MACs. There are a number of other contracting approaches that could be introduced within or in addition to the cost-reimbursement structure. Without formally assessing the potential benefits and risks of alternative contracting approaches, CMS may be missing opportunities to enhance MACs' efficiency and effectiveness.

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**Abbreviations**

CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
FAR	Federal Acquisition Regulation
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	Department of Health and Human Services
MAC	Medicare Administrative Contractor
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
PPACA	Patient Protection and Affordable Care Act
PSC	Program Safeguard Contractor
ZPIC	Zone Program Integrity Contractor

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April 30, 2015

## Congressional Requesters

Medicare funds health care services for approximately 54 million beneficiaries.<sup>1</sup> Since 2006, the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—has used regional contractors called Medicare Administrative Contractors (MAC) to process claims for health care items and services submitted by 1.5 million enrolled Medicare providers and suppliers. Among other things, MACs are responsible for enrolling health care providers in the Medicare program, processing and paying Medicare Part A and Part B fee-for-service claims, and handling the first-level of appeals for denied claims.<sup>2</sup> In fiscal year 2013, these contractors processed almost 1.2 billion fee-for-service Medicare Part A and Part B claims, which totaled more than \$363.3 billion in payments for Medicare services. CMS paid approximately \$1.3 billion to the MACs for these services in fiscal year 2013.

When the Medicare program was established, claims administration contractors were not selected through a competitive process, and CMS's authority to terminate these contracts was limited.<sup>3</sup> Beginning in the

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<sup>1</sup>See Centers for Medicare & Medicaid Services, *Financial Report for Fiscal Year 2014*, pub. no. 952014 (Baltimore, Md.: Nov. 10, 2014).

<sup>2</sup>Medicare consists of four parts. Parts A and B are known as original Medicare or Medicare fee-for-service. Medicare Part A covers inpatient hospital care, skilled nursing facility care, some home health services, and hospice care. Part B services include physician and outpatient hospital services, diagnostic tests, mental health services, outpatient physical and occupational therapy, ambulance services, some home health services, prosthetics, orthotics, and supplies. Part C is the private health plan alternative to Medicare fee-for-service and primarily consists of plans that are offered under the Medicare Advantage program. Part D is the outpatient prescription drug benefit, which is provided through private plans.

<sup>3</sup>Prior to 2003, Medicare law required CMS to choose fiscal intermediaries—contractors that handled Medicare Part A and Part B claims from hospitals, other institutions, and home health agencies—from among organizations that were first selected by associations representing providers. The law also required CMS to select health insurers or similar companies to be carriers, which handled Medicare Part B claims from physicians and other providers, including durable medical equipment suppliers. CMS could not terminate contracts with fiscal intermediaries or carriers unless the contractors were first provided with an opportunity for a hearing.

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1980s, HHS asked Congress to amend CMS's authority to select Medicare claims administration contractors, seeking reforms that would promote competition, improve contractors' services to beneficiaries and providers, achieve cost savings, and increase CMS's ability to reward high-performing contractors. In 2003, Congress included contracting reform provisions in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Among other things, the MMA requires CMS to use competitive procedures to select MACs; offer them incentives to provide quality service and promote efficiency; develop standards to assess their performance; and comply with the Federal Acquisition Regulation (FAR) except where inconsistent with specific MMA provisions.<sup>4</sup> If a MAC has met or exceeded performance requirements, the MMA authorizes CMS to renew the contract from term to term without the application of competitive procedures, so long as CMS periodically recompetes MAC contracts. Under the MMA, CMS was required to recompete MAC contracts at least once every 5 years, but the Medicare Access and CHIP Reauthorization Act of 2015, enacted on April 16, 2015, now requires that CMS recompete these contracts at least once every 10 years.<sup>5</sup>

In 2006, CMS started transitioning Medicare claims administration tasks from the 51 legacy contractors to the MACs.<sup>6</sup> To do this, CMS established multistate, defined geographic areas, called jurisdictions, where MACs would serve Medicare providers, suppliers, and beneficiaries. As of March 2014, there were 12 jurisdictions in which MACs administered Part A and Part B Medicare claims (these MACs are referred to as A/B MACs) and 4 jurisdictions in which MACs administered Medicare claims for durable

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<sup>4</sup>The FAR establishes uniform policies for acquisition of supplies and services by executive agencies. 48 C.F.R. ch.1.

<sup>5</sup>Pub. L. No. 114-10, § 509(a)-(b) (April 16, 2015).

<sup>6</sup>CMS officials use the term "legacy contractors" to describe both carriers and fiscal intermediaries that administered claims under contracts established before 2003. The last fiscal intermediary and carrier contracts ended in August and September 2013, respectively.

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medical equipment (DME), prosthetics, orthotics, and supplies (referred to as DME MACs).<sup>7</sup>

In March 2010, we reported on CMS's progress and challenges in establishing the first MAC contracts, and we found that, while the agency had taken steps to facilitate the complex implementation of contracting reform, the sample of MACs we reviewed did not meet all of CMS's performance requirements at that time. We also found that CMS did not track total costs and savings associated with the implementation of Medicare contracting reform.<sup>8</sup> In January 2014, the HHS Office of Inspector General issued a report assessing the extent to which MACs had met CMS's performance standards and evaluating CMS's monitoring of the MACs' performance.<sup>9</sup> The Office of Inspector General report examined MACs' performance between September 2008 and August 2011 and found that MACs included in the review did not meet one-quarter of CMS's quality assurance standards, that CMS did not always require corrective action plans for unmet standards, and that unmet standards without corrective action plans were more likely to remain unresolved.<sup>10</sup> The Office of Inspector General also found that, while CMS performed extensive reviews of MACs' performance, the agency had not always completed these reviews in a timely manner.

As it has now been more than 10 years since the enactment of the MMA and about 8 years since the first MACs began administering Medicare claims, you asked GAO to provide an updated assessment of CMS's implementation of contracting reform and to examine whether CMS could make improvements to increase MACs' effectiveness. This report examines (1) differences in responsibilities among MACs and the costs

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<sup>7</sup>Claims administered by A/B MACs include those for inpatient hospital care, skilled nursing facility care, home health care services, hospice care, physician and outpatient hospital services, diagnostic tests, mental health services, outpatient physical and occupational therapy, and ambulance services.

<sup>8</sup>GAO, *Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards*, [GAO-10-71](#) (Washington, D.C.: Mar. 25, 2010).

<sup>9</sup>Department of Health and Human Services Office of Inspector General, *Medicare Administrative Contractors' Performance*, OEI-03-11-00740 (Washington, D.C.: January 2014).

<sup>10</sup>The Office of Inspector General report included data from 13 MACs—9 A/B MACs and 4 DME MACs—that had been operational for at least 2 years as of January 2012.

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associated with these responsibilities, including any changes since the implementation of contracting reform; (2) lessons learned, if any, since CMS implemented contracting reform that could be used to increase MAC efficiency and effectiveness; and (3) alternative contracting approaches that CMS could consider to enhance contractor performance.

To examine differences in responsibilities among MACs and the costs associated with these responsibilities, including any changes since the implementation of contracting reform, we compared contract documents, including MACs' statements of work, and interviewed CMS officials about changes to the scope of MACs' responsibilities since 2006, the year the first MAC became operational.<sup>11</sup> Additionally, we obtained information from CMS on MACs' coordination with other Medicare contractors—such as Recovery Auditors—to determine whether responsibilities have shifted to or from MACs or whether MACs have experienced increased workloads as a result of coordination with other contractors.<sup>12</sup> We obtained cost reports from CMS for 9 of the 12 A/B MACs and all four of the DME MACs for which full contract year data were available during the period of our review. The data we obtained were for costs reported by each MAC during the most recent full contract year for which data were available as of April 2014.<sup>13</sup> The cost reports we obtained detailed the amounts each MAC spent by key responsibility area, such as claims processing, provider enrollment, and medical review. We analyzed these reports to calculate the average amounts spent by the 9 A/B MACs and by the 4 DME MACs on each responsibility area and the average percentages of MACs' total costs that were accounted for by each

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<sup>11</sup>For the purposes of this report, we will use the term "MAC responsibilities" to refer to the functional requirements listed in each MAC's statement of work, which outlines the requirements that the MAC must fulfill in order to honor the terms of its contract. These responsibilities include claims processing, provider customer service, and medical review.

<sup>12</sup>Recovery Auditors are responsible for conducting postpayment claims reviews to identify improper payments. They are paid a contingency fee from the Medicare overpayments that they recoup. The Recovery Auditors were established through a demonstration program under the MMA, piloted between 2005 and 2008, and were later made permanent under the Tax Relief and Health Care Act of 2006, which required CMS to establish Recovery Auditors for all states before 2010.

<sup>13</sup>A MAC contract performance period is 1 year, but the dates of MAC contract years vary depending on when each MAC contract was awarded. The cost reports for the 13 A/B and DME MACs in our review included costs reported between December 2010 and February 2014. Our analysis did not include costs reported by 3 of the 12 A/B MACs because full contract year data for these 3 MACs were not available during the period of our review.



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responsibility area. To assess the reliability of CMS's data on MACs' reported costs, we manually reviewed the cost reports for obvious errors or missing data and interviewed knowledgeable CMS officials. We found these data to be sufficiently reliable for examining differences in the costs associated with MACs' key responsibilities. We calculated the average amounts spent by the A/B MACs and by the DME MACs—rather than comparing the MACs' actual costs—to account for any differences in responsibilities among the MACs and differences in the dates on which the MACs reported the costs we analyzed.

To examine lessons learned that could be used to increase MAC efficiency and effectiveness, we reviewed CMS documents and interviewed CMS officials regarding experiences since the implementation of contracting reform. Additionally, we interviewed officials from four MACs that hold contracts for 7 of the 12 A/B MAC jurisdictions and one of the four DME MAC jurisdictions.<sup>14</sup> Collectively, the four MACs we interviewed are responsible for about 58 percent of the estimated A/B MAC claims volume and about 20 percent of the estimated DME MAC claims volume. In these interviews, we discussed lessons the MACs have learned since the implementation of Medicare contracting reform and improvements they have implemented that have helped them operate more efficiently and effectively. We also discussed the extent to which CMS solicits ideas from the MACs about these operational efficiencies.

To examine alternative contracting approaches that CMS could consider to enhance contractor performance, we reviewed CMS documents, including the agency's 2007 MAC acquisition strategy and contract justification documents. We also reviewed recent award fee plans for MACs that were operational at the time we requested these documents, in February 2014. We then examined alternative contracting approaches that are available under the FAR and analyzed the potential benefits and risks of each alternative in regard to whether it could enhance MAC performance. Finally, we interviewed CMS officials to discuss the extent to which they had considered alternative contracting approaches since the initial implementation of the MAC contracts.

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<sup>14</sup>We selected MACs to interview on the basis of whether the MAC had completed a minimum of the base year and the first option year for at least one MAC contract. We also selected three of the four MACs in our sample because they held contracts for more than one MAC jurisdiction. In addition, we selected one A/B MAC that held a contract for a jurisdiction that included responsibility for home health and hospice claims.

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We conducted this performance audit from January 2014 to April 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

### MAC Jurisdictions

When implementing contracting reform, CMS initially planned to establish 15 A/B MAC jurisdictions and 4 DME MAC jurisdictions. At that time, CMS also planned to award four additional MAC contracts for processing Medicare claims for home health and hospice care, but the agency later decided to divide this workload among four of the A/B MAC contracts instead of establishing separate contracts for home health and hospice care. Since the initial implementation of contracting reform, CMS has consolidated some of the A/B MAC jurisdictions so that, as of February 2015, there were 12 A/B MAC jurisdictions. (See apps. I, II, and III for maps of the A/B, DME, and Home Health and Hospice MAC jurisdictions that were operational as of February 2015.)

### Existing MAC Contract Structure and Incentives

Under the FAR, CMS could choose from two broad types of contract structures for the MAC contracts—fixed-price contracts and cost-reimbursement contracts. Because of uncertainty about the amount of costs MACs would likely incur during the initial implementation of the MAC contracts, CMS opted to structure the MAC contracts as a cost-plus-award-fee contract, which is a type of cost-reimbursement contract that allows an agency to provide financial incentives to contractors if they achieve specific performance goals.<sup>15</sup> In its 2007 MAC acquisition strategy, CMS stated that fixed-price contracts for MACs would be difficult to administer because little was known about the expected costs of these

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<sup>15</sup>Under the FAR, cost-reimbursement contracts are suitable for use only when circumstances do not allow the agency to define its requirements sufficiently, or when uncertainties involved in contract performance do not permit costs to be estimated with sufficient certainty to use any type of fixed-price contract. 48 C.F.R. § 16.301-2. We do not question CMS's decision to select a cost-reimbursement contract structure for the MACs.

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contracts in light of the concurrent implementation of several other new Medicare initiatives, such as the Part D prescription drug benefit and Medicare Advantage plans, among other things.<sup>16</sup> Agency officials also said that they believed a cost-plus-award-fee contract structure would allow CMS to stress the importance of quality performance over the course of the contracts and would accommodate frequent changes in MACs' workloads or responsibilities that CMS anticipated handling over the course of the contracts. CMS decided to structure each MAC contract with a 1-year base performance period and four optional 1-year performance periods.<sup>17</sup>

Under the cost-plus-award-fee contract, MACs receive a base fee, which is fixed at the inception of the contract, plus reimbursement for allowable costs.<sup>18</sup> The MACs also may earn an incentive, known as an award fee, based on their performance on standards that are defined by CMS in advance of each 1-year performance period. During the procurement process, MAC offerors propose to CMS the amounts of the base fees and award fees they would like to be eligible to earn over the course of their contracts, which are subject to negotiation to arrive at the final base and award fee amounts with successful offerors. For the MACs that were in operation as of January 2014, base fees represented about 1 to 3 percent of the MACs' total contract values, while the award fees that the MACs

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<sup>16</sup>CMS detailed its plans for the procurement of the first MAC contracts in a June 2007 acquisition strategy document, which was required under the FAR and described, among other things, the reasoning behind CMS's decision to structure the MAC contracts as cost-plus-award-fee contracts, the schedule by which CMS planned to conduct the initial MAC procurements, and the criteria that offerors had to meet to be considered for a contract award.

<sup>17</sup>CMS decided to structure the MAC contracts with 1-year base performance periods and four optional 1-year performance periods at the time the MMA requirement that these contracts be recompeted at least once every 5 years was still in effect. The recent enactment of the Medicare Access and CHIP Reauthorization Act of 2015 amended this requirement to authorize a maximum 10-year performance period before MAC contracts must be recompeted. The amendment, which applies to MAC contracts in effect at the time of enactment or entered into on or after enactment, would permit CMS to modify existing MAC contracts or enter into future MAC contracts for 1-year base performance periods and nine optional 1-year performance periods. See Pub. L. No. 114-10, § 509(a)-(b) (April 16, 2015).

<sup>18</sup>Under the FAR, costs must meet five criteria to be allowable. The costs must (1) be reasonable, (2) be allocable, (3) meet cost accounting standards, (4) meet the contract terms, and (5) not be subject to any limitations set forth in FAR subpart 31.2. See 48 C.F.R. ch. 31.

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were eligible to earn represented about 1 to 5 percent of the total contract values.<sup>19</sup> Over the course of MAC contracts, prior to the start date for each 1-year performance period, CMS can revise the metrics included in MACs' award fee plans and adjust the distribution of award fees across the metrics to promote performance in high-priority areas and to emphasize areas where MACs may be able to influence a positive programmatic outcome.

For the 12 A/B MACs that were in operation as of January 2014, the total estimated value for the 5-year contract period—if all option years are exercised—is over \$5.2 billion, with the total estimated contract values ranging from about \$326 million to \$609 million per A/B MAC. For the four DME MACs that were in operation as of January 2014, the estimated 5-year contract value—if all option years are exercised—is about \$624 million. Estimated 5-year contract values for the DME MACs ranged from about \$92 million to \$257 million per MAC. See table 1 for details about the ranges of base fees and available award fee pools that CMS estimated the MACs in operation as of January 2014 were eligible to earn over the course of their 5-year contracts.

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<sup>19</sup>GAO found through an evaluation of Department of Defense contracts that award fees typically account for 15 percent or less of total contract values. See GAO, *Defense Acquisitions: DOD Has Paid Billions in Award and Incentive Fees Regardless of Acquisition Outcomes*, [GAO-06-66](#) (Washington, D.C.: Dec. 19, 2005).

**Table 1: Ranges of Base Fees, Available Award Fee Pools, and Estimated Allowable Costs That Medicare Administrative Contractors (MAC) in Operation as of January 2014 Were Eligible to Earn Over the Course of Their 5-Year Contracts**

Fee or cost, by type of MAC	Minimum	Mean	Maximum
<b>12 A/B MACs</b>			
Base fee	\$3.0 million	\$7.7 million	\$12.7 million
Available award fee pool	\$2.9 million	\$10.7 million	\$27.6 million
Allowable costs (estimated)	\$303.5 million	\$412.8 million	\$574.9 million
<b>Total contract value (estimated)<sup>a</sup></b>	<b>\$317.2 million</b>	<b>\$431.6 million</b>	<b>\$609.1 million</b>
<b>4 durable medical equipment (DME) MACs</b>			
Base fee	\$1.2 million	\$2.4 million	\$3.5 million
Available award fee pool	\$3.5million	\$4.2 million	\$4.7 million
Allowable costs (estimated)	\$106.3 million	\$165.2 million	\$249.3 million
<b>Total contract value (estimated)<sup>a</sup></b>	<b>\$111.6 million</b>	<b>\$172.0 million</b>	<b>\$256.7 million</b>

Source: Centers for Medicare & Medicaid Services. | GAO-15-372

<sup>a</sup>The base fee, available award fee pool, and estimated allowable costs do not necessarily sum to the total contract values listed in this table because the figures are drawn from different contracts.

## CMS Oversight of the MACs

For each MAC, CMS develops a statement of work that outlines the functional requirements—or responsibilities—that the MACs are to fulfill over the course of their contracts. CMS oversees MACs' performance in carrying out the responsibilities outlined in their statements of work in a variety of ways, including but not limited to the following:

- **Reviewing MACs' quality control plans.** Under their statements of work, each MAC is responsible for developing a quality control plan, which must be submitted to CMS within 45 days after the contract is awarded and updated annually thereafter, when the contract is renewed for additional option years.<sup>20</sup> CMS reviews the MACs' quality control plans and approves them after ensuring that they include all required elements. Among other things, the quality control plan specifies procedures—such as an audit and inspection system and a formal system for implementing corrective actions—to which the MAC will adhere, in order to ensure that the MAC meets its contract performance requirements.

<sup>20</sup>The MACs may also be required to update their quality control plans in other circumstances, such as when substantive changes occur that affect the quality control plan.

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- **Assessing MACs' performance on the quality assurance surveillance plan.** Consistent with the FAR, CMS develops a quality assurance surveillance plan to outline performance standards that all MACs are expected to meet, in accordance with their statements of work. At the end of each contract year, CMS assesses each MAC's performance on the set of surveillance plan standards that CMS has established for each of 11 different business function areas.<sup>21</sup> For example, one business function area is provider customer service, and two of the quality assurance surveillance plan standards for that area relate to the timeliness of the MAC's responses to telephone and written inquiries from providers. After CMS completes its annual surveillance plan review for each MAC, the MACs have an opportunity to dispute CMS's assessment or provide more information that may result in a change to the MAC's performance score. In some cases, CMS may require that the MAC complete an action plan to address deficiencies cited in the quality assurance surveillance plan review.
  - **Assessing MACs' performance through Contractor Performance Assessment Reporting System reviews.** At the end of each contract year, CMS is required to prepare a Contractor Performance Assessment Reporting System report for each MAC, which provides an overall rating of each MAC's performance during the contract year.<sup>22</sup> To prepare the reports, CMS officials use information about MACs' performance that they gather through various sources, such as the MACs' cost reports, the results of quality control plan and quality assurance surveillance plan reviews, and award fee evaluations. Using information aggregated from all of these sources, CMS rates the MACs in areas such as quality, schedule, cost control, business relations, and personnel management. The Contractor Performance Assessment Reporting System stores these reports electronically and makes them available for other federal agencies to review in the event that an entity holding a MAC contract later competes for other federal contracts.

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<sup>21</sup>The 11 business function areas included in the quality assurance surveillance plan are: appeals, audit and reimbursement (A/B MACs only), claims processing, debt management, Freedom of Information Act, financial management, medical review, Medicare secondary payer, provider customer service program, provider enrollment (A/B MACs only), and beneficiary customer service.

<sup>22</sup>The base year of each MAC contract is comprised of an implementation period and an operational period of performance, each of which requires a separate Contractor Performance Assessment Reporting System report, but these two reports are completed only after the end of the base year of the contract.

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- ***Assessing MACs' performance on metrics included in their award fee plans.*** Award fees are the key performance incentive included in the type of cost-reimbursement contract CMS selected for the MACs under the FAR. Award fee plans include fewer performance standards than the quality assurance surveillance plan and are intended to (among other things) reward MACs for being innovative, cost-effective, and collaborative for the overall benefit of the Medicare program. CMS develops the award fee plan and, at the end of each contract year, reviews MACs' performance on the standards included in the plan, to determine whether each MAC is eligible to earn some, all, or none of its available award fee pool.<sup>23</sup> CMS assigns a certain percentage of the award fee to each of the performance standards included in the plan. To be eligible to earn any percentage of the award fee, the MAC must achieve at least a "satisfactory" rating in each performance element under its most recent Contractor Performance Assessment Reporting System evaluation, signifying that it has substantially met all cost, schedule, and technical performance requirements of its contract. Further, the MAC must meet all or almost all of the significant criteria included in its award fee plan. MACs that perform at this level are eligible to earn up to 50 percent of their award fees. Only MACs that exceed all or almost all of the significant award fee criteria while also substantially meeting all cost, schedule, and technical performance requirements of their contracts are eligible to earn up to 100 percent of their award fees and an "excellent" rating for the award fee. MACs generally have not earned all of the award fees for which they have been eligible. For example, in its January 2014 report, the HHS Office of Inspector General analyzed data from two performance periods and found that MACs had earned between 35 and 86 percent of their overall award fee pools.

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<sup>23</sup>Based on our review of MACs' award fee plans, CMS generally changes the performance standards included in the award fee plan for each year of the MACs' contracts.

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## MACs' Responsibilities Are Generally Similar and Have Remained Consistent Since Contracting Reform

Responsibilities of the MACs Are Functionally Similar across All Contracts and Have Generally Remained Consistent Since Contracting Reform, with Limited Exceptions

MACs have a number of key responsibilities related to the Medicare program, as outlined in their statements of work, and these responsibilities have generally remained the same since contracting reform began in 2006. Among the responsibilities, MACs are charged with processing Medicare claims submitted by providers—which involves processing the claim to the point of payment, denial, or other action—in a timely and accurate manner. In addition, MACs are responsible for conducting medical reviews of claims to determine whether the claims are for services covered by the Medicare program and whether the services were medically necessary. MACs also handle first-level appeals, or requests for redeterminations for any claims that were initially denied. Further, the MACs are responsible for maintaining a Medicare provider customer service program, which has three main components: a provider outreach and education program, a contact center to handle provider inquiries, and self-service technology for providers to access Medicare information at any time. For descriptions of MACs' key responsibilities, see appendix IV.

According to CMS officials, with limited exceptions, MACs' responsibilities are functionally similar across all of the MAC contracts. One exception is that there are slight differences between the responsibilities of the A/B MACs and those of the DME MACs. For example, DME MACs are not responsible for enrolling medical equipment suppliers in the Medicare program, whereas the A/B MACs have the responsibility of enrolling providers and suppliers. Enrollment of medical equipment suppliers is handled centrally by the National Supplier Clearinghouse contractor.

Another exception is that the MACs can have different jurisdiction-specific responsibilities. For instance, some MACs serve jurisdictions in which Medicare Strike Force teams are located. The Medicare Strike Force teams investigate and prosecute potential fraud in specific locations with a high historic level of program fraud. The MACs provide additional support, perform special analyses, and carry out follow-up actions for



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certain providers as requested by the Strike Force teams. Additionally, certain MACs have had jurisdiction-specific responsibilities related to Medicare demonstration projects regarding specific types of providers, such as rural community hospitals, or for specific activities or services, including enrollment of providers that offer home health services.

Although MACs' responsibilities are generally similar across each of the contracts, CMS officials told us that the MACs often have different workloads for certain responsibilities, based on factors such as the provider mixes in their jurisdictions. For example, some MAC jurisdictions have a large number of long-term care hospitals. Since these types of hospitals may receive higher payments for the services they provide than other types of hospital providers, the MACs must review information about the long-term care hospitals they serve to ensure that hospitals qualify for the higher payments. As a result, these MACs may spend more time and resources than MACs with fewer long-term care hospitals would spend fulfilling contract requirements associated with processing claims from long-term care hospitals.

CMS officials also told us that the responsibilities of the MACs have generally remained the same since the implementation of contracting reform, although legislative changes have affected some of the MACs' workloads for certain responsibilities. One such change was the creation of the nationwide Recovery Auditor Program by the Tax Relief and Health Care Act of 2006, which changed how Medicare claims are reviewed after they have been paid to identify any improper payments. Prior to the implementation of the nationwide recovery auditor program in 2010, the MACs were responsible for conducting post-payment reviews to recover improper payments, but the Recovery Auditors now conduct the bulk of these reviews. If the Recovery Auditor finds overpayments of certain claims, the MACs recover those overpayments from the providers. Although the MACs are conducting fewer postpayment reviews than they originally did, CMS officials told us that the MACs' workload for recovering overpayments identified by the Recovery Auditors' reviews has

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increased.<sup>24</sup> Additionally, the Patient Protection and Affordable Care Act (PPACA) required the revalidation of providers' and suppliers' eligibility to participate in the Medicare program. Although the A/B MACs and the National Supplier Clearinghouse have always had responsibility for provider enrollment, the PPACA requirement to revalidate providers was added to the A/B MACs' and the National Supplier Clearinghouse's responsibilities. As of November 2014, the MACs and the National Supplier Clearinghouse had sent revalidation notices to more than 1.04 million Medicare providers and suppliers.

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**Most of MACs' Reported Costs Were Accounted for by Certain Key Responsibilities, Such as Claims Processing and Provider Customer Service**

Although there were some differences between A/B MACs' and DME MACs' reported costs, most of the reported costs for both the A/B MACs and the DME MACs were for a few key responsibilities. On average, both the A/B MACs and the DME MACs reported a large portion of their costs were incurred for similar activities, including claims processing and the Provider Customer Service Program. However, the A/B MACs reported a higher average percentage of their costs for financial management than did the DME MACs. Additionally, on average, the DME MACs reported a higher portion for appeals than did the A/B MACs.

For the nine A/B MACs included in our review, the total costs reported by all nine MACs were \$732.1 million. These MACs' reported total costs for their respective full contract years ranged from \$41.4 million to \$132.9 million, with an average of \$81.3 million per MAC. Four responsibility areas—claims processing, financial management, Provider Customer Service Program, and provider enrollment—accounted for about 60 percent of the nine A/B MACs' reported costs during the most

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<sup>24</sup>In July 2014, we issued a report that examined the efficiency and effectiveness of postpayment claims reviews conducted by Medicare contractors, including recovery auditors. See GAO, *Medicare Program Integrity: Increased Oversight and Guidance Could Improve Effectiveness and Efficiency of Postpayment Claims Reviews*, [GAO-14-474](#) (Washington, D.C.: July 18, 2014). According to CMS, overpayments identified by the Recovery Auditors and collected by the MACs increased from about \$75 million in fiscal year 2010 to about \$2.29 billion in fiscal year 2012.

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recent full contract year for which cost data were available.<sup>25</sup> Four other key responsibilities accounted for about 26 percent of the A/B MACs' reported costs: appeals (about 7 percent), medical review (about 7 percent), administrative requirements (about 7 percent), and infrastructure requirements (about 6 percent).<sup>26</sup> The nine A/B MACs in our review incurred the remainder of their reported costs—about 14 percent—for other responsibilities, such as reopening of initial claims determinations, the Medicare secondary payer program, and jurisdiction-specific requirements.<sup>27</sup> See table 2 for the average costs and percentages of A/B MACs' total reported costs, by key responsibility area, for the most recent full contract year for which data were available for MACs that were in operation at the time of our review.

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<sup>25</sup> Claims processing costs are those associated with processing Medicare claims to the point of payment, denial, or other adjudicative action. Financial management costs include those incurred by MACs to comply with CMS's financial accounting and reporting requirements, as well as CMS's statement of work requirements for institutional provider cost report review, audit, and reimbursement. Provider Customer Service Program costs include those associated with conducting provider outreach and education, maintaining a provider contact center to handle provider inquiries, and establishing provider self-service technology to allow providers to access Medicare information at any time of day. Provider enrollment costs are related to the activities MACs carry out to screen provider applications, validate application information, and ensure that providers have not been excluded from participating in the Medicare program.

<sup>26</sup> Appeals costs are those associated with reviewing Medicare claims and supporting documentation and determining whether an initial claim decision should be affirmed, partially reversed, or fully reversed when beneficiaries, providers, or other eligible parties request that the MAC reconsider the claim. Medical review costs are those associated with reviewing records to determine whether Medicare services were medically necessary. Costs associated with administrative requirements include those associated with security, quality assurance, and public relations, among others. Costs associated with infrastructure requirements include those related to MACs' telecommunication activities and management of electronic data.

<sup>27</sup> Costs associated with reopening of Medicare initial claims determinations include those where the MAC exercises its discretion to reopen a claim in order to change the final determination that resulted in an overpayment or an underpayment. Only 4 of the 12 A/B MACs process home health and hospice claims. Medicare secondary payer program costs are those the MAC incurs to ensure that plans with primary insurer liability have paid before Medicare makes payment. Costs associated with jurisdiction-specific requirements are those incurred by the MACs for conducting certain jurisdiction-specific responsibilities outlined in their statements of work, such as coordinating with Medicare Strike Force teams to assist with their investigations of potential fraud.

**Table 2: Average Costs and Percentages of Nine A/B Medicare Administrative Contractors' (MAC) Total Costs Accounted for by Key Responsibility Area**

Key Responsibility Area	Average yearly costs reported by nine A/B MACs (in millions)	Average yearly percentage of total costs reported by nine A/B MACs
Claims processing	\$20.5	25.1%
Financial management	11.9	14.6
Provider Customer Service Program	9.2	11.4
Provider enrollment	7.3	9.0
Appeals of Medicare initial claims determinations	6.0	7.3
Medical review	5.6	6.8
Administrative requirements	5.3	6.5
Infrastructure requirements	4.5	5.5
Reopening of Medicare initial claims determinations	3.6	4.5
Medicare secondary payer	1.5	1.8
Other responsibilities <sup>a</sup>	7.4	7.5
<b>Total</b>	<b>81.3</b>	<b>100.0</b>

Source: GAO analysis of CMS data. | GAO-15-372

Note: Cost reports were for the most recent full contract year for which data were available for 9 of the 12 A/B MACs that were in operation at the time of GAO's review. However, since the time period during which the contract year occurs can be different for each MAC, the full-year cost reports for the MACs in our review included costs reported between September 2011 and February 2014.

<sup>a</sup>Other responsibilities include home health and hospice requirements, workload implementation and closeout requirements, making local coverage determinations, rural health clinics, and jurisdiction-specific requirements. While most of these responsibilities are included in all MAC contracts, home health and hospice requirements only apply to 4 A/B MACs, as these MACs have contracts to process home health and hospice claims in one of four jurisdictions across the nation. Our analysis only includes costs from two of the four A/B MACs that process home health and hospice claims.

For the DME MACs, most costs were incurred for only a few responsibility areas. Nearly three-quarters of DME MACs' reported costs were for claims processing (about 28 percent), appeals (about 18 percent), the Provider Customer Service Program (about 17 percent), and Zone Program Integrity Contractor support services (about 11 percent).<sup>28</sup> For the DME MACs that were included in our review, the total costs reported by all four MACs were \$127.3 million. The four DME MACs' reported costs for their respective full contract years ranged from \$20.3 million to

<sup>28</sup>Zone Program Integrity Contractors are responsible for identifying potential fraud; investigating it in a timely manner; and taking swift action, such as working to revoke suspect providers' Medicare billing privileges and referring potentially fraudulent providers to law enforcement. CMS awarded contracts to the first Zone Program Integrity Contractors in 2008.

\$48.5 million, with an average of \$31.8 million. See table 3 for the average costs and percentages of DME MACs' total reported costs, by key responsibility area, for the most recent full contract year for which data were available for MACs that were in operation at the time of our review.

**Table 3: Average Costs and Percentages of Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC) Total Costs Accounted for by Key Responsibility Area**

Key Responsibility Area	Average costs reported by All DME MACs (in millions)	Average percentage of total costs reported by All DME MACs
Claims processing	\$8.8	27.7%
Appeals	5.8	18.2
Provider Customer Service Program	5.5	17.2
Zone Program Integrity Contractor support services	3.4	10.8
Financial management	1.7	5.4
Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative <sup>a</sup>	1.4	4.4
Reopening of Medicare claims determinations	1.2	3.9
Other responsibilities <sup>b</sup>	4	12.4
<b>Total</b>	<b>31.8</b>	<b>100.0</b>

Source: GAO analysis of CMS data. | GAO-15-372

Note: Cost reports were for the most recent full contract year for which data were available for 4 DME MACs that were in operation at the time of GAO's review. However, since the time period during which the contract year occurs can be different for each MAC, the full contract year cost reports for the MACs in our review included costs reported between December 2010 and February 2014. Additionally, the cost report data for one DME MAC was for 395 days instead of 365 days.

<sup>a</sup>The HEAT Initiative is a joint effort between the Department of Health and Human Services and the Department of Justice to fight health care fraud. A key component of this effort is the Medicare Fraud Strike Force, an interagency team of analysts, investigators, and prosecutors who target fraud schemes. MACs are responsible for recovering Medicare funds from fraudulent providers identified through the HEAT initiative.

<sup>b</sup>Other responsibilities include change management process requirements, administrative requirements, and infrastructure and quality assurance requirements.

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## CMS and MACs Have Identified Lessons Learned to Improve MAC Operations, but Also Challenges for Continued Improvements

Since the Implementation of Contracting Reform, CMS and the MACs Have Identified Lessons Learned and Made Improvements to Increase Operational Efficiency and Effectiveness

Officials from CMS and the MACs we interviewed agreed that they have learned many lessons since the initial implementation of the MAC contracts, and together, they have implemented improvements to increase the MACs' operational efficiency and effectiveness. The MACs' statements of work outline CMS's expectation that the MACs will continuously refine their business processes to foster efficiencies to promote the best value for the government and use innovative solutions to improve program operations.

CMS officials we interviewed explained that they routinely encourage, solicit, and review ideas from MACs about how to improve their operational efficiency and effectiveness. These officials explained that they have gathered ideas about increasing efficiency and effectiveness from the MACs in the following ways:

- In contract solicitations, CMS instructs MAC offerors to propose programmatic or operational innovations they would implement if awarded a MAC contract and to describe the expected benefits of the proposed innovations.
- When MACs are transitioning into each new contract, CMS requires them to formally submit lessons learned documents, which detail challenges or other insights identified by MACs while transferring operations from previous contractors. These lessons learned may be beneficial to other MACs during future contract implementation periods.
- In the fall of 2013, CMS created an innovations submissions mailbox for the MACs to send in improvement or innovation requests. The MACs are to use this system when they want to implement a new process, service, technology, or other improvement, but there are funding needs or other contract requirements that CMS must approve in order for the MAC to implement the planned improvement.

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- CMS convenes meetings annually with MAC executives, and they often discuss process improvement ideas at these meetings.
  - CMS also acknowledges MACs' ideas for significant process improvement through the Contractor Performance Assessment Reporting System, a web-based application it uses to record MAC performance evaluations.
  - CMS and the MACs have convened workgroups related to various key responsibilities, in which the MACs collaborate and share ideas.

According to CMS officials, when a particular MAC's innovations have merit across the MAC community, CMS will incorporate the practices into subsequent MAC statements of work, to spread the operational improvement to other MACs.

Officials from CMS and the four A/B MACs and one DME MAC we interviewed listed the following examples of lessons learned and innovations that some of the MACs have implemented since the implementation of contracting reform:

- **Provider self-service portals.** Three of the four A/B MACs and the one DME MAC we interviewed said that they had developed Internet-based provider self-service portals, which allow providers to validate their eligibility, submit claims electronically, request claim reconsiderations, and check the status of claims and reconsiderations, among other things. MAC officials said that this has reduced their expenditures on resources devoted to telephone-based provider customer service.
- **Data analytics.** Officials from one A/B MAC described how they have begun using data analytics to more effectively identify provider-specific patterns of billing errors so that they can conduct targeted outreach and education to providers and try to prevent future billing errors.
- **Clinical editing software.** CMS officials described the software that one MAC has deployed to improve the effectiveness of its prepayment edits. The software enables the MAC to electronically flag errors in Medicare claims that are not likely to meet the criteria for Medicare payment when the provider submits the claim for payment, rather than after the MAC begins processing the claim. The MAC explained that the provider is then offered an opportunity to correct errors before transmitting the claim to the MAC for payment. This reduces the resources this MAC must devote to the appeals process, the CMS officials said.

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- **Representation at administrative law judge hearings.** Another MAC described an innovation it had piloted in its DME MAC jurisdiction, which CMS has since required of all A/B and DME MACs. The innovation addresses the rate at which the MACs' decisions to deny coverage for Medicare services or DME were being overturned at administrative law judge hearings, which are convened when the MAC and a Medicare qualified independent contractor have both determined that a claim should be denied and the beneficiary or provider disagrees with that determination.<sup>29</sup> In the past, the MACs did not send representatives to these hearings, and many of the disputed claims were ultimately paid. The MACs now send physicians to administrative law judge hearings to represent the MAC and explain why it denied payment for claims that are the subject of the hearings. More of the MACs' initial determinations are being upheld, which results in savings of Medicare dollars, the MAC said.

CMS officials said that the agency includes in its MAC performance reviews an assessment of whether the MAC has generated ideas or process improvements that add value to the government. These ideas and innovations are documented in the Contractor Performance Assessment Reporting System, which may contribute to a favorable past performance evaluation for the MAC when its contract is recompeted.

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## CMS and the MACs Have Identified Some Challenges for Continued Improvements in MAC Efficiency and Effectiveness

While they have made various changes since the implementation of contracting reform, officials we interviewed from both CMS and the MACs described some challenges created by the structure of the MAC contracts that may constrain continued improvements in MAC efficiency and effectiveness. One challenge CMS officials identified was the 5-year limit on MAC contract terms, which they said constrained their ability to respond to issues with MACs' performance. These officials stated that they were reluctant to decide not to exercise an option year for a MAC based on performance issues. According to the officials, it was impractical to award a new contract within the 5-year contract terms permitted by the MMA because it takes approximately 18 to 24 months to solicit, award, and implement a new MAC contract. The officials said they would be

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<sup>29</sup>If a Medicare beneficiary, his or her representative, or a provider or supplier disagrees with the MAC's initial coverage and payment determination, they may appeal the determination, and the MAC must make a redetermination. If the appellant still disagrees after the MAC's redetermination, the appellant may file a second-level appeal with a Medicare qualified independent contractor.



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more likely to consider replacing MACs midcontract if the contracts lasted longer than 5 years. To illustrate this, CMS officials told us that they had issued only one written notification to a MAC, advising that the agency might not exercise a contract option year—unless the contractor improved its performance—since the implementation of contracting reform. According to the CMS officials, the MAC ultimately improved its performance after receiving the notice, but CMS’s decision to continue the contract was also partially influenced by the agency’s conclusion that the potential benefit of replacing the MAC before the end of its contract term was outweighed by the risks and costs that would be associated with recompeting the contract sooner than planned.

In addition, the CMS officials we interviewed stated that a potential benefit of increasing the time between MAC contract competitions could be that CMS and the MACs would have more time to develop innovations and that the MACs would have more time to implement them to yield performance improvements. The MAC officials we interviewed echoed these sentiments. The officials we interviewed from CMS and the MACs said they would support a legislative change to increase the maximum time between MAC contract competitions from 5 years to 10 years. In its January 2014 report, the HHS Office of Inspector General recommended that CMS seek legislation increasing the limit on MAC contract duration. The Medicare Access and CHIP Reauthorization Act of 2015, enacted in April 2015, increased the maximum time between MAC contract competitions to 10 years.<sup>30</sup>

According to the MAC officials we interviewed, the competitive nature of the MAC contracting environment has made MACs reluctant to share certain innovations or operational improvements with other MACs. The MAC officials said that they must balance CMS’s desire for them to share innovations with other MACs with trying to protect any competitive advantages they have in the contracting environment. From the perspective of officials from two of these MACs, collaboration and sharing of ideas was more widespread among the legacy contractors, which were not selected through competitive processes. After the initial transition from the legacy contractors to MACs, officials from one MAC said that there was a period of time when MACs may have overvalued a particular improvement or innovation as being proprietary or a competitive

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<sup>30</sup>Pub. L. No. 114-10, § 509(a)-(b) (April 16, 2015).

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advantage and been reluctant to share ideas with other MACs. In the view of this contractor, MACs have since become more willing to share ideas that are retrospective and aimed at fixing past problems. However, they still want to protect true innovations, which are ideas that address problems more prospectively and aim to find better ways of fulfilling their contract requirements.

CMS officials also described their recent decision to delay for 5 years the planned consolidation of two pairs of A/B MAC jurisdictions, based on their experiences with the recent consolidation of three other pairs of A/B MAC jurisdictions. In 2010, CMS announced that it planned to consolidate the 15 original A/B MAC jurisdictions to 10 jurisdictions before 2017.<sup>31</sup> Consolidations had been implemented in three pairs of A/B MAC jurisdictions by February 2014, but CMS decided in March 2014 that it would delay for 5 years the consolidation of the two remaining pairs of MAC jurisdictions. The agency gave several reasons for this decision. First, CMS officials found that operational cost reductions associated with the first three consolidations were smaller than expected, and they were concerned that merging the remaining two pairs of A/B MAC jurisdictions could affect contractor performance negatively in key areas, including provider customer service. CMS was also concerned about the heightened complexity of the final two MAC jurisdiction consolidations because some of the affected jurisdictions were responsible for home health and hospice workloads. Finally, CMS was concerned about the business landscape that has evolved since the implementation of contracting reform. According to the CMS officials we interviewed, MACs conduct highly specialized work and, in the view of the officials, few other potential contractors would be capable of performing such specialized work successfully. The agency has already limited the share of the A/B MAC workload that can be serviced by a single contractor or affiliated

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<sup>31</sup>CMS's 2010 announcement indicated that the agency planned a phased approach to implement the consolidation of five pairs of MAC jurisdictions. In 3 of the 5 pairs of jurisdictions, CMS planned to consolidate the jurisdictions at the end of the MACs' first 5-year contract terms, when the MAC contracts were already set to be recompeted. In the remaining 2 pairs of jurisdictions, the first 5-year MAC contract terms had yet to commence in at least one of the two jurisdictions as of 2010 because of bid protests or procurement corrective actions. In these cases, CMS planned to consolidate the jurisdictions where the first 5-year contract terms had yet to commence with jurisdictions where contracts had already been implemented and resolicit proposals for one contract.

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contractors.<sup>32</sup> Because some of the current contractors operate with almost the maximum workload CMS has specified that a single contractor can hold, CMS was concerned that further A/B MAC workload consolidations and reductions in the number of MAC marketplace participants could constrain CMS's ability to respond to other challenges that might arise.

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## CMS Has Informally Considered Some Alternative Contracting Approaches but Could Do More to Assess Whether They Could Enhance MAC Performance

While CMS has made modifications to its cost-plus-award-fee structure for MAC contracts—such as revising the metrics included in MACs' award fee plans and adjusting the distribution of award fees across the metrics to promote performance in high-priority areas and areas where MACs have performed poorly in the past—the agency has not formally revisited its MAC contracting approach since the implementation of contracting reform. According to the FAR, changing circumstances may make certain contracting approaches more appropriate later in the course of a series of contracts or a long-term contract than they were at the outset. Moreover, CMS indicated in its 2007 acquisition strategy that once a baseline cost and level of effort had been established, the agency would reassess whether the cost-plus-award-fee contract structure was still appropriate for the MACs. However, CMS's assessment of alternative contracting approaches since the implementation of contracting reform has been limited.

In recent contract justification documents, CMS has indicated why a firm fixed-price contract structure remains an unsuitable approach for MAC contracts and included a limited discussion of why the use of incentive fees—a type of fee available under the cost-reimbursement contract structure—would not be appropriate for MACs.<sup>33</sup> These contract justification documents fulfill CMS's responsibility under the FAR to document the circumstances, facts, and reasoning behind taking individual contract actions (such as entering into a contract in a given

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<sup>32</sup>Since 2010, CMS limited the share of workload that any single A/B MAC or set of affiliated A/B MACs can hold. A single A/B MAC contractor cannot be responsible for more than 26 percent of the Medicare Part A and Part B claims volume nationwide, and a set of affiliated A/B MAC contractors are limited to 40 percent of the Medicare Part A and Part B claims volume.

<sup>33</sup>Prior to executing any new MAC contract, CMS must prepare contract justification documents, which are known as determinations and findings. These documents detail the agency's findings about why its intended contracting approach is appropriate.

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MAC jurisdiction). In addition, the FAR also requires agencies to perform acquisition planning and, where a written evaluation plan is required, to review their acquisition plans and revise them as appropriate at key dates specified in the plan or whenever significant changes occur, but at least annually. While CMS's decision to continue using the cost-reimbursement contract structure for the MAC contracts may be appropriate, there are a number of other contracting approaches that could be introduced within or in addition to the cost-reimbursement structure. CMS officials have discussed some of them internally but not documented any formal assessments of the alternatives by revising CMS's 2007 MAC acquisition strategy. A comparative evaluation of the possible costs and benefits of alternative contracting approaches would provide a more evidence-based rationale for CMS's chosen approach for the MAC contracts. Without formally assessing the potential benefits and risks of alternative contracting approaches, CMS lacks assurance that the current contract structure is the optimal method for incentivizing MACs' performance, and CMS may be missing opportunities to enhance MACs' efficiency and effectiveness.

Following are four examples of potential alternative contracting approaches which may be permissible under the FAR, if properly documented and approved, along with some of the potential risks and benefits that CMS could consider. While some of these approaches are not explicitly mentioned in the FAR, they are also not prohibited. The FAR allows agencies to develop and test new acquisition methods, provided they are not explicitly precluded by federal law, executive order, or regulation.

- ***Using award terms.*** One type of incentive available to CMS is the award term. Unlike the contract option years that exist under CMS's current MAC contracting approach, which CMS can exercise at its discretion once it has complied with the FAR requirements for exercising an option, award terms would incentivize MACs' performance by automatically extending their contracts, as long as they met preestablished performance requirements.

CMS officials told us that, while they had not documented an assessment of this alternative, they had discussed it internally and concluded that the statutory 5-year limit on MAC contract terms limited the potential of the award-term approach to serve as a greater motivator to MACs' performance than the option years that are available under the existing cost-plus-award-term contract structure. We agreed that award terms may be a greater performance motivator

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if MAC contracts lasted longer than 5 years; however, there was nothing that would have precluded CMS from adopting the award-term approach within the 5-year terms for MAC contracts. For example, CMS could have restructured MAC contracts so that years two and three would be option years, and years four and five would be award-term years. CMS had not formally analyzed the potential risks and benefits of the award-term approach in the context of the 5-year contract term or compared these to the current option year approach. Given the recent legislative change that will permit MAC contracts to last up to 10 years, the award term approach may have more potential than CMS previously thought. Among the factors that CMS could consider would be whether this incentive could increase or decrease CMS's administrative costs associated with monitoring MACs' performance over the course of their contracts and the extent to which the agency may need to revise its performance metrics or thresholds, if at all, in order to accommodate the implementation of award terms.

- **Implementing negative performance incentives.** Under the FAR, agencies can also establish cost-reimbursement contracts with negative performance incentives. For example, under this type of contract, CMS theoretically could deduct from MACs' base fees if they failed to meet certain performance thresholds. Alternatively, CMS could include nonmonetary negative incentives in MAC contracts, such as reducing the length of the contract if the MAC failed to meet established performance thresholds. For example, the contract could provide that, if a MAC's performance fell below a certain level, CMS could reduce the length of the last option year of the contract by 3 months. For even lower levels of performance, CMS could impose reductions of 6 months, 9 months, or 1 year.

The CMS officials we interviewed had not documented an assessment of whether monetary or nonmonetary negative incentives for poor performance would be appropriate for MAC contracts. However, they said that they had discussed it internally and concluded that the targets for existing MAC performance metrics are too high to accommodate negative performance incentives. For example, the CMS officials said that, while other federal contracts may require contractors to meet a certain requirement 80 percent of the time, MACs are required to meet many of their requirements 95 to 100 percent of the time.

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- **Transitioning certain elements within the MAC contracts to a fixed-price structure.** In 2007, CMS documented its rationale for using a cost-reimbursement contract structure for the MAC contracts. However, while maintaining the overall cost-reimbursement contract structure, CMS could use a fixed-price contract structure for separate contract components; that is, CMS could set a firm price separately for certain contract responsibilities. In that case, the MACs would only be paid according to the fixed price for each contract component that was set at the beginning of the contract.

In its 2007 acquisition strategy and more recent contract justification documents, CMS concluded that it would be too difficult to predict at the outset of each contract the workloads and specific costs that could be incurred for each of the MACs' responsibilities. That is, CMS has stated that the fixed-price contract structure is not appropriate because legislative changes in Medicare coverage and payment policy, as well as other factors outside CMS's and the MACs' control, could cause the agency to make near-constant technical changes to MACs' contracts over the course of each contract term.

CMS officials we interviewed said they had engaged in some internal discussions about whether there were any elements within MACs' contracts that could be transitioned from a cost-reimbursement to a fixed-price contract structure, but they had not formally analyzed the feasibility of doing so or which contract responsibilities have the potential to be appropriate for a fixed-price contract structure. Given that CMS has been collecting MAC cost reports for more than 8 years, the agency has the data it would need to analyze the potential benefits or risks of transitioning certain MAC responsibilities to a fixed-price structure. For example, while it may not be appropriate to transition the responsibilities of provider enrollment or medical review to a fixed-price structure—because of the unpredictability of future workloads MACs could incur for these particular responsibilities—CMS could evaluate whether it would be appropriate to transition certain other MAC requirements—such as certain claims processing production activities—to a fixed-price approach.

- **Transitioning certain elements of the MAC contracts to an incentive fee structure.** Another contracting approach available to CMS is the incentive fee. Under this arrangement, CMS would establish target costs that it would expect each MAC to incur for each contract responsibility. Using an agreed-upon formula that CMS would negotiate with each MAC, if the total costs reported by the contractor were less than the target costs, the contractor would earn a total fee that is greater than the target fee. If the total costs were greater than

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the target costs, the MAC would earn a total fee that is less than the target fee. For example, each MAC is required to have a Provider Customer Service Program to educate providers on Medicare requirements and respond to their inquiries. Using historical cost data, CMS could establish a target cost for these programs and incentivize the MACs to reduce costs in this area through techniques such as encouraging providers to use self-service information portals rather than seeking information through written inquiries.

CMS officials told us that they initially decided against using the cost-plus-incentive-fee contract structure for MACs because they believed that changing Medicare requirements precluded the establishment of specific cost, schedule, or performance targets from the outset of contracting reform, and CMS's recent contract justification documents continue to reflect that belief. There is no indication, however, that CMS has engaged in an analysis that might help identify whether there are certain MAC responsibilities for which the cost-plus-incentive-fee approach might be feasible, without transitioning to this approach for all MAC contract responsibilities. Now that CMS has more experience with MAC contracts and has more data on past costs and performance for MACs' key responsibilities, CMS may be able to identify selected responsibilities that could be transitioned to an incentive fee structure.

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## Conclusion

CMS has accumulated a considerable amount of data on MACs' reported costs and performance under the cost-plus-award-fee contract structure the agency established when the first MACs became operational 8 years ago. The FAR states that certain contracting approaches may be more appropriate later in the course of a series of contracts or a long-term contract than they were at the outset, and CMS indicated in its 2007 acquisition strategy that it would revisit its contracting approach once it had collected baseline information. However, CMS has not engaged in a formal analysis of whether several other contracting approaches have the potential to increase MACs' efficiency and effectiveness. Instead, recent contract justification documents have included a limited assessment of potential alternatives. Without using the wealth of data it has collected since the implementation of contracting reform to analyze other available contracting approaches, CMS may be missing opportunities to increase MACs' efficiency and effectiveness.

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## Recommendation for Executive Action

We recommend that CMS conduct a formal analysis, using its experience and data it has collected since the implementation of the first MAC contracts, to determine whether alternative contracting approaches could be used—even if only for selected MAC contract responsibilities—to help promote improved contractor performance.

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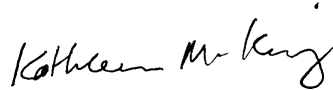
## Agency Comments and Our Evaluation

We provided a draft of this report to HHS and received written comments, which are reprinted in appendix V. In its comments, HHS concurred with this recommendation and said it plans to analyze alternative contracting approaches for MACs. Finally, HHS provided technical comments, which we addressed as appropriate.

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As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from its issuance date. At that time, we will send copies to the Secretary of Health and Human Services, appropriate congressional committees, and other interested parties. In addition, the report will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs are on the last page of this report. GAO staff who made major contributions to this report are listed in appendix VI.



Kathleen M. King  
Director, Health Care



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*List of Requesters*

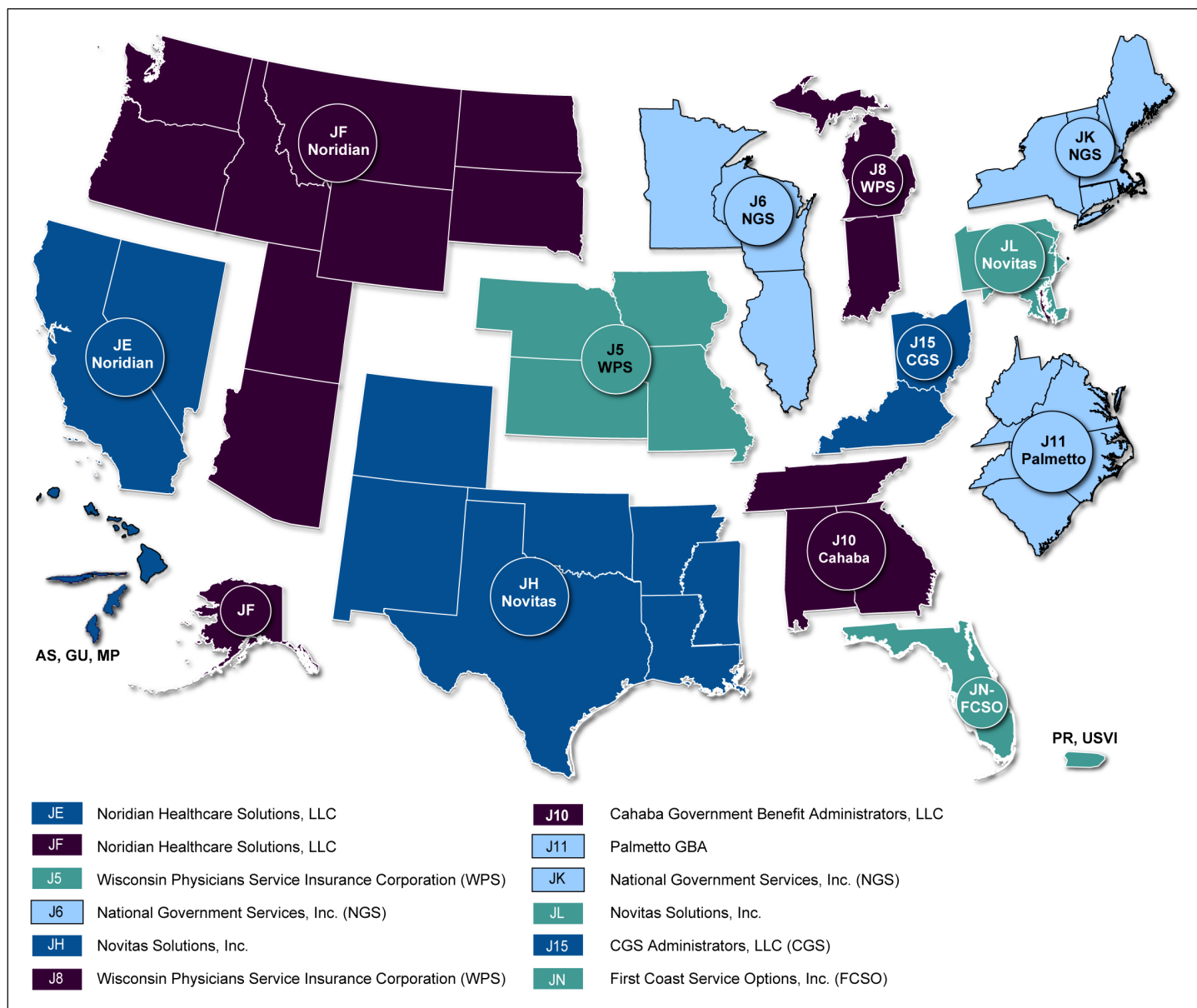
The Honorable Orrin Hatch  
Chairman  
Committee on Finance  
United States Senate

The Honorable Bob Corker  
United States Senate

The Honorable Charles Boustany, M.D.  
Chairman  
Subcommittee on Human Resources  
Committee on Ways and Means  
House of Representatives

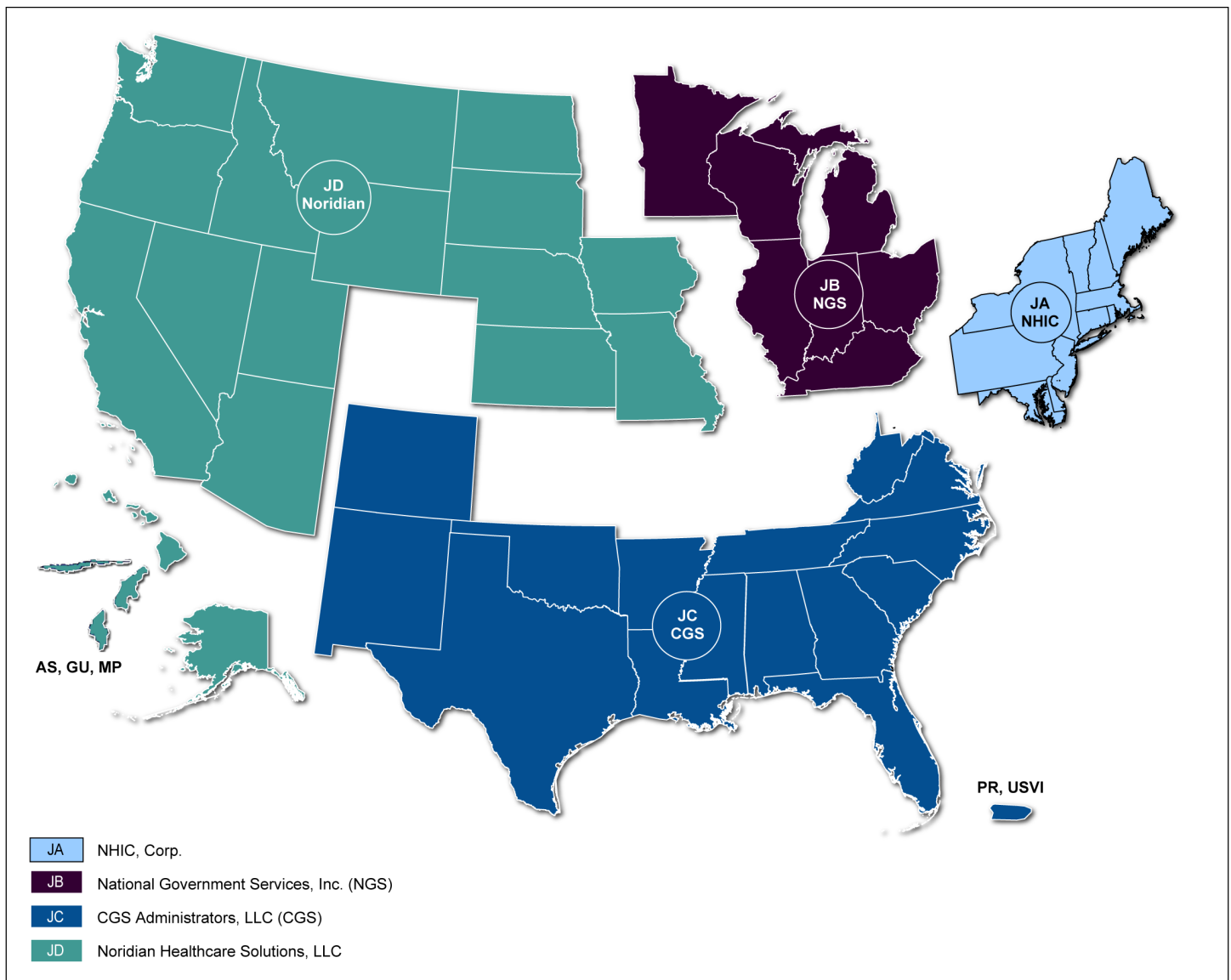
The Honorable Peter Roskam  
Chairman  
Subcommittee on Oversight  
Committee on Ways and Means  
House of Representatives

# Appendix I: Jurisdictional Map for Part A/B Medicare Administrative Contractors, as of February 2015



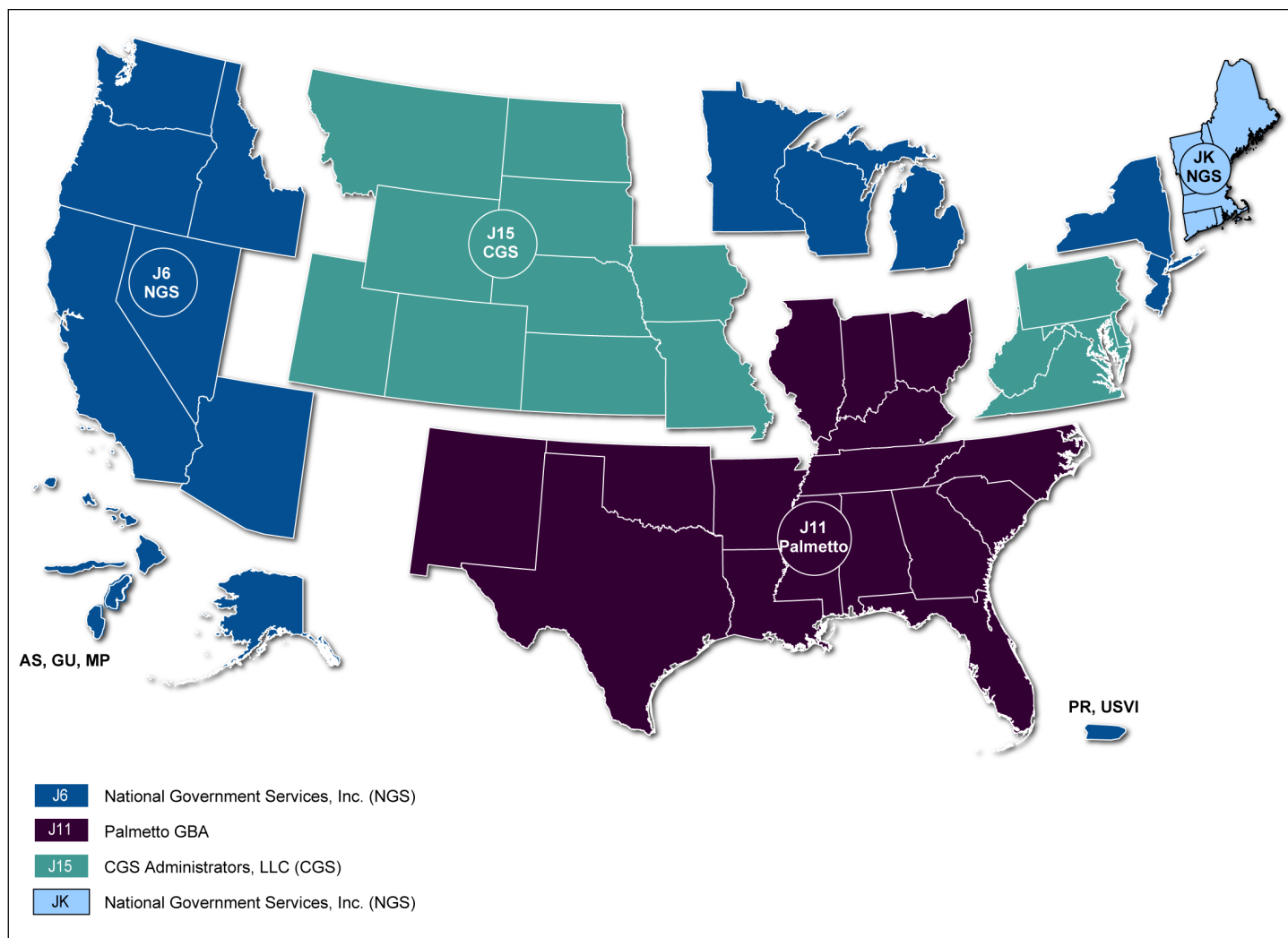
Source: Centers for Medicare & Medicaid Services; Map Resources (map). | GAO-15-372

# Appendix II: Jurisdictional Map for Durable Medical Equipment Medicare Administrative Contractors, as of February 2015



Source: Centers for Medicare & Medicaid Services; Map Resources (map). | GAO-15-372

# Appendix III: Jurisdictional Map for Home Health and Hospice Medicare Administrative Contractors, as of February 2015



Source: Centers for Medicare & Medicaid Services; Map Resources (map). | GAO-15-372

# Appendix IV: Key Responsibilities of Medicare Administrative Contractors (MAC)

Key responsibility	Description
Claims processing	MACs are to process Medicare claims to the point of payment, denial, or other adjudicative action in a timely and accurate manner. Additionally, MACs are responsible for adhering to all claims processing rules outlined in CMS's Internet-only manuals.
Provider enrollment <sup>a</sup>	MACs are to process provider applications for enrollment in the Medicare program, including prescreening of applications, verifying and validating the information in the enrollment application, and ensuring that the applying providers are not excluded from participation in the Medicare program.
Provider Customer Service Program	<p>MACs are responsible for establishing a Provider Customer Service Program to assist providers in understanding and complying with Medicare's operational policies, billing procedures, and processes. The Program is to enable providers to understand, manage, and bill Medicare correctly, with the goal being to reduce the Medicare paid claims error rate and improper payments. Each MAC's program should consist of three major components:</p> <ul style="list-style-type: none"> <li>• Provider outreach and education for educating providers and their staff,</li> <li>• Provider contact center for handling provider inquiries, and</li> <li>• Provider self-service technology, including technology that allows access to Medicare information at any time of the day.</li> </ul>
Medical review	MACs are to decrease the paid claims errors in coverage, coding, and billing through the Medical Review program. The Medical Review program is designed to promote a structured approach to how Medicare policy is interpreted and implemented, which often requires the review of medical records to determine whether the services were medically necessary.
Medicare secondary payer	MACs are responsible for implementing a comprehensive Medicare Secondary Payer program, which is intended to ensure that plans with primary insurer liability pay before Medicare pays for a particular service.
Local coverage determinations	<p>A local coverage determination is a decision made by a MAC to cover a particular item or service on a MAC-wide basis, in accordance with the Social Security Act (i.e., a determination as to whether the item or service is reasonable and necessary).</p> <p>MACs are to publish local coverage determinations to provide guidance to the public and medical community within their jurisdictions. MACs are to develop local coverage determinations by considering medical literature, advice of local medical societies and consultants, public comments, and comments from providers. Additionally, MACs are to ensure that all local coverage determinations are consistent with statutes, rulings, regulations, and national policies related to coverage, payment, and coding.</p>
Reopening of Medicare initial claims determinations	A reopening of a Medicare claim is a remedial action taken to change the final determination that resulted in an overpayment or an underpayment, even though the determination was correct based on the evidence of record. Reopenings are separate from the appeals process and are a discretionary action on the part of the MAC. The MAC's decision to reopen a claim determination is not an initial determination and is not appealable.

**Appendix IV: Key Responsibilities of Medicare  
Administrative Contractors (MAC)**

<b>Key responsibility</b>	<b>Description</b>
First-level appeals of Medicare initial claims determinations	A party dissatisfied with the MAC's initial determination about Medicare coverage for items or services has the right to request within 120 days that the MAC review its initial determination. Within 60 days of receiving the request for redetermination, a MAC employee who did not take part in the initial determination must review the claim and supporting documentation and issue a redetermination either affirming, partially reversing, or fully reversing the MAC's initial determination. Parties permitted to appeal initial determinations include beneficiaries and their representatives, states, providers, physicians, and other suppliers.
Coordination with Program Safeguard Contractors/Zone Program Integrity Contractors	MACs are responsible for deterring and detecting fraud and abuse. The MACs may receive information about fraud or abuse from several sources, including provider inquiries or medical review, and are required to refer all suspected cases to the Program Safeguard Contractors (PSC) or Zone Program Integrity Contractors (ZPIC) for investigation. Additionally, MACs should communicate with the PSCs and ZPICs to coordinate efforts and prevent duplication of review activities.
Financial management	MACs are responsible for maintaining accounting records in accordance with specific government accounting principles and applicable government laws and regulations. MACs are expected to report financial activity to CMS in accordance with the financial reporting requirements set forth in CMS's Internet-only manuals and the MACs' statements of work. Additionally, the MACs are responsible for receiving, reviewing, and auditing (as necessary) institutional provider cost reports.
Program Management Office	MACs are responsible for establishing and maintaining a Program Management Office, which has defined management processes and organization in order to successfully carry out the responsibilities of the contract. One part of the Program Management office requires the MACs to communicate with CMS officials about a variety of issues.
Infrastructure requirements	MACs are required to establish or use infrastructure to carry out the requirements of the contract. This includes telecommunication activities and management of electronic data.
Administrative requirements	MACs are to comply with various administrative requirements that outline specific needs for carrying out the contract, such as key personnel, security, quality assurance, public relations, responding to congressional inquiries, participation in meetings and workgroups, continuity planning and disaster preparedness, internal controls, and compliance program.

Source: GAO analysis of CMS's Internet only manuals and MACs' statements of work. | GAO-15-372

<sup>a</sup>The A/B MACs are responsible for the provider enrollment area. DME MACs do not have this responsibility, as it is handled centrally by another contractor.

# Appendix V: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation  
Washington, DC 20201

**APR 17 2015**

Kathleen M. King  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street NW  
Washington, DC 20548

Dear Mrs. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "*Medicare Administrative Contractors: CMS Should Consider Whether Alternative Approaches Could Enhance Contractor Performance*" (GAO-15-372).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

A handwritten signature in cursive script, reading "Jim R. Esquea", is positioned above the printed name.

Jim R. Esquea  
Assistant Secretary for Legislation

Attachment

**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADMINISTRATIVE CONTRACTORS: CMS SHOULD CONSIDER WHETHER ALTERNATIVE APPROACHES COULD ENHANCE CONTRACTOR PERFORMANCE (GAO-15-372)**

The U.S. Department of Health and Human Services (HHS) appreciates the opportunity from the Government Accountability Office (GAO) to review and comment on this draft report. HHS is committed to further improving the quality of beneficiary and provider services and reducing costs through the use of Medicare Administrative Contractors (MACs).

The MACs were created to improve Medicare's claims administration services to beneficiaries and health care providers. The replacement of the decades-old legacy Medicare claims contracts with the MACs represents a very significant agency accomplishment. HHS began the transition from the legacy Medicare claims contractors to the MACs in 2006, had implemented more than 65% of all Medicare Fee-for-Service (FFS) claims workload to the MACs by 2010, and completed implementation of the final MAC contract jurisdiction in September 2013.

With the application of competitive procedures and performance-based contracting concepts to the acquisition of MAC contracts, the Centers for Medicare & Medicaid Services (CMS) has reduced Medicare FFS claims administration costs by several hundred million dollars since implementation, even as the scope of MAC responsibilities and the number of beneficiaries have increased. As a result, the Medicare FFS program has derived significant reductions in per-claim and per-beneficiary administrative costs over the past decade. During the same period, the MACs have achieved substantial gains in their overall operational performance, and have developed and implemented innovative and cost-effective solutions to the Medicare FFS program's evolving requirements.

As noted by GAO, CMS continues to re-compete the MAC contracts every five years as required by statute. The competitive environment established through Medicare Contracting Reform has sharpened CMS's focus on MAC contract performance and efficiency. The introduction of competition and contract incentives has catalyzed technical innovations, such as provider portals, that have increased MAC productivity and improved provider satisfaction. In addition, CMS has made major strides in its approaches to contractor management and oversight, improving the overall functioning of the Medicare FFS program. Through the implementation of Medicare Contracting Reform, CMS has established a Medicare FFS contracting framework that allows for comprehensive, quality care and improved beneficiary and provider services.

Throughout the past decade, as CMS has implemented the MACs, CMS has identified many "lessons learned" that we continue to apply through an on-going series of process improvements to fine-tune our acquisition and administration of the MACs. For instance, CMS has established a stream-lined, integrated approach to managing the numerous mandated changes to Medicare FFS claims operations. The FFS program environment requires that CMS and the MACs handle a steady stream of changing priorities and workloads, as manifested by the more than four



**GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE ADMINISTRATIVE CONTRACTORS: CMS SHOULD CONSIDER WHETHER ALTERNATIVE APPROACHES COULD ENHANCE CONTRACTOR PERFORMANCE (GAO-15-372)**

hundred Changes Requests (CRs) and more than four hundred Technical Direction Letters issued each year by CMS.

**GAO Recommendation**

GAO recommends that CMS conduct a formal analysis, using its experience and data it has collected since the implementation of the first MAC contracts, to determine whether alternative contracting approaches could be used—even if only for selected MAC contract responsibilities—to help promote improved contractor performance.

**HHS Response**

HHS concurs with the recommendation. The MAC program has generated considerable savings, administrative efficiencies, and performance improvements, and HHS will continue to focus on improving its MAC acquisition processes to generate further improvements in all phases of the MAC contract life-cycle. With the “lessons learned” and data collected to date, HHS will conduct a formal analysis of the MAC program to determine if further refinement of the MAC contract structure (and supporting MAC oversight processes) would be beneficial.

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# Appendix VI: GAO Contact and Staff Acknowledgments

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## GAO Contact

Kathleen M. King, (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, William T. Woods, Director; Martin T. Gahart, Assistant Director; Christie Enders; John Krump; Victoria Klepacz; Alexis C. MacDonald; Elizabeth T. Morrison; Mary Quinlan; and Jennifer Whitworth were major contributors to this report.

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# Related GAO Products

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*Medicare Program Integrity: Increased Oversight and Guidance Could Improve Effectiveness and Efficiency of Postpayment Claims Reviews.* [GAO-14-474](#). Washington, D.C.: July 18, 2014.

*Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency.* [GAO-13-522](#). Washington, D.C.: July 23, 2013.

*Medicare Program Integrity: Few Payments in 2011 Exceeded Limits under One Kind of Prepayment Control, but Reassessing Limits Could Be Helpful.* [GAO-13-430](#). Washington, D.C.: May 9, 2013.

*Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment.* [GAO-13-102](#). Washington, D.C.: November 13, 2012.

*Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards.* [GAO-10-71](#). Washington, D.C.: March 25, 2010.

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